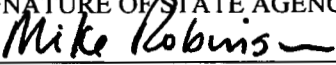



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 02-16	2. STATE Kentucky
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE 07/01/02	
5. TYPE OF PLAN MATERIAL ( <i>Check One</i> ):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT ( <i>Separate Transmittal for each amendment</i> )			
6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.325		7. FEDERAL BUDGET IMPACT: a. FFY 02                      \$0 b. FFY 03                      \$0	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-B page 20.22		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT ( <i>If Applicable</i> ):  Same	
10. SUBJECT OF AMENDMENT: Targeted Case Management Service Payments.			
11. GOVERNOR'S REVIEW ( <i>Check One</i> ):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL		<input checked="" type="checkbox"/> OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services	
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: Mike Robinson		Frances McGraw Eligibility Policy Branch Department for Medicaid Services 275 East Main Street 6W-C Frankfort, Kentucky 40621	
14. TITLE: Commissioner, Department for Medicaid Services			
15. DATE SUBMITTED: 9/30/02			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED: September 30, 2002		18. DATE APPROVED: December 24, 2002	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2002		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Rhonda R. Cottrell		22. TITLE: Associate Regional Administrator Division of Medicaid and Children's Health	
23. REMARKS:			

## XXIII. Case Management Services

A. Targeted case management services for severely emotionally disturbed children and adults with chronic mental illness.

Providers are paid a uniform interim rate. The uniform interim rate approximates an average of provider actual costs from the previous year. Prior to July 1, 2002, the uniform interim rate was settled to individual provider actual cost at the end of the state's fiscal year. Providers are required to submit an independently audited cost report as acceptable documentation of actual cost.

The billable unit of service is one month.

For state fiscal year July 1, 2002 - June 30, 2003, the uniform interim rate will be the final rate, and will not be settled to provider actual cost.

B. Targeted case management services for children with developmental disabilities provided through an agreement with the Title V Agency.

Payments for case management services are on a per encounter or per item basis. Payments shall be based on documented costs for the direct provision of services. Documented costs do not include payment for administrative and indirect overhead costs of the Title V agency or its contractor state agency, the Department for Mental Health and Mental Retardation Services. The Title V Agency, (or its contractor state agency, the Department for Mental Health and Mental Retardation Services) must maintain, in auditable form, all records of expenditures for services for which claims of reimbursement are made to the Medicaid agency. Payments to state agencies shall not exceed actual documented costs. An interim rate based on projected cost may be used as necessary with a settlement to cost at the end of the fiscal year.